AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Client Name _____ **Chart Number** _____

Social Security Number _____-_____-_____ **Birth Date** _____/_____/_____

Provider Name/ Address _____

_____

_____

_____

I, _____, hereby authorize the above-named healthcare provider to furnish and/or receive pertinent medical **(specifically, records relating to my HIV/AIDS status)** and social services records and documents relating to my medical history, my mental and physical condition, services rendered and all treatment provided to me, to:

Program Name/ Address _____

_____

_____

_____

I understand that as part of my application for services through _____, my medical condition must be evaluated to determine eligibility for case management and provide ongoing case management and related services. Information released pursuant to this authorization will be used solely for the purpose of administering this program.

Additionally, I hereby authorize _____ to fax information to the State Office of AIDS.

This authorization is **effective today**, and shall remain in effect until such time as I revoke it in writing or until **two years from the date signed**.

I understand that I have a right to receive a copy of this authorization.

Signed _____ **Date** _____
(Client/Legal Representative)

If signed by other than the client, indicate relationship

_____